



6/15

**Department of Health, Office of Facilities Regulation**  
**Assisted Living Residence - Five (5) Day Investigation Report**  
Completed reports are to be faxed or emailed to the Office of Facilities Regulation.  
**FAX: (401) 222-5901, Email: doh.ofr@health.ri.gov**

|  |        |                 |  |
|--|--------|-----------------|--|
| Facility Name:   |        | Date:           |  |
| Reported by:   | Title: | Contact Number: |  |
| Date that the incident/allegation occurred:                        |        |                 |  |
| Date incident/allegation was initially reported to the Department: |        |                 |  |

**Incident Category.** Please select the most appropriate:

|   |  |
|---|--|
| <input type="checkbox"/> <b>Accident/Incident</b><br><input type="checkbox"/> <b>Resident to Resident Abuse</b><br><input type="checkbox"/> <b>Staff to Resident(s) Abuse</b><br><input type="checkbox"/> <b>Neglect</b><br><input type="checkbox"/> <b>Misappropriation/Exploitation of property/resources</b><br><input type="checkbox"/> <b>Implementation of fire/evacuation/disaster plan</b><br><input type="checkbox"/> <b>Elopement</b> | <input type="checkbox"/> <b>Death:</b> <ul style="list-style-type: none"><li>• Within 24 hours of admission</li><li>• Sudden or unexpected</li><li>• Suspicious</li><li>• Unnatural</li><li>• Result of trauma</li><li>• Unattended by a physician</li></ul> |
|---|--|

**Resident(s) Information:**

|            |  |        |  |
|------------|--|--------|--|
| Last Name: |  | First: |  |
| Last Name: |  | First: |  |

**Alleged Perpetrator(s) Information** *(if applicable):*

|            |  |        |  |
|------------|--|--------|--|
| Last Name: |  | First: |  |
| Last Name: |  | First: |  |

**Brief Description of Incident:**

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**Results of Investigation:** *(include current status of any injured resident(s):*

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**Facility system changes made to decrease the risk of similar incidents from occurring:**

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**\*Administrator Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_